

8411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09532

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakehurst, N.J.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) E R Aiken		4. DATE OF DEATH JULY 27 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1923
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AD-1 USN		10b. KIND OF BUSINESS OR INDUSTRY USN	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME L.T. Aiken		14. MOTHER'S MAIDEN NAME Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) active		16. SOCIAL SECURITY NO. 259 16 1760	
17. INFORMANT U.S. Navy records, Lakehurst, N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE SEVERE INJURIES 860X DUE TO Conditions, if any, which gave rise to immediate cause (b) HELICOPTER CRASH (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HELICOPTER CRASHED	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12N p. m. 7-27- 1959		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) NR EASTON TALBOT MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) LOUIS S. WELTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/28/59	
22c. NAME OF CEMETERY OR CREMATORY Naval Hosp.		22d. LOCATION (City, town, or county) (State) Phila. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Rrampton Carroll		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR Arthur S. Kneass		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

Item 3, Film G245, 7/24/59
CERTIFICATE OF DEATH

08365

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot 8385 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton Md.				c. LENGTH OF STAY IN TB 3 hrs. 30 m			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 103 Corner St.			
3. NAME OF DECEASED (Type or print) First William Middle CARTER Last Batter				4. DATE OF DEATH Month 7 Day 18 Year 1959			
5. SEX M	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1918	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Easton, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Carter Sr.				14. MOTHER'S MAIDEN NAME Nannie Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. Ruby Carter Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, Essential Vas. 3 yrs DUE TO (c) 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 3 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1958 to July 18, 1959 that I last saw the deceased alive on July 18, 1959 and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ray M. Reaser Jr. M.D.				ADDRESS (Street, city or town, state) St Michael's Md DATE SIGNED 7-18-59			
PHYSICIAN'S NAME (Type) Ray M. Reaser Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-21-59		22c. NAME OF CEMETERY OR CREMATORY Diamond Town Cemetery		22d. LOCATION (City, town, or county) (State) Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE Stamilton Harrison, St Michael's Md ADDRESS				24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 65	
4. DATE OF DEATH 10/15/1950		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF NEXT OF KIN [Signature]		14. SIGNATURE OF BURIAL OFFICIAL [Signature]		15. SIGNATURE OF CHURCH OFFICIAL [Signature]	
16. SIGNATURE OF FUNERAL HOME [Signature]		17. SIGNATURE OF CEMETERY [Signature]		18. SIGNATURE OF INTERVIEWER [Signature]	
19. SIGNATURE OF INTERVIEWER [Signature]		20. SIGNATURE OF INTERVIEWER [Signature]		21. SIGNATURE OF INTERVIEWER [Signature]	
22. SIGNATURE OF INTERVIEWER [Signature]		23. SIGNATURE OF INTERVIEWER [Signature]		24. SIGNATURE OF INTERVIEWER [Signature]	
25. SIGNATURE OF INTERVIEWER [Signature]		26. SIGNATURE OF INTERVIEWER [Signature]		27. SIGNATURE OF INTERVIEWER [Signature]	
28. SIGNATURE OF INTERVIEWER [Signature]		29. SIGNATURE OF INTERVIEWER [Signature]		30. SIGNATURE OF INTERVIEWER [Signature]	
31. SIGNATURE OF INTERVIEWER [Signature]		32. SIGNATURE OF INTERVIEWER [Signature]		33. SIGNATURE OF INTERVIEWER [Signature]	
34. SIGNATURE OF INTERVIEWER [Signature]		35. SIGNATURE OF INTERVIEWER [Signature]		36. SIGNATURE OF INTERVIEWER [Signature]	
37. SIGNATURE OF INTERVIEWER [Signature]		38. SIGNATURE OF INTERVIEWER [Signature]		39. SIGNATURE OF INTERVIEWER [Signature]	
40. SIGNATURE OF INTERVIEWER [Signature]		41. SIGNATURE OF INTERVIEWER [Signature]		42. SIGNATURE OF INTERVIEWER [Signature]	
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49. SIGNATURE OF INTERVIEWER [Signature]		50. SIGNATURE OF INTERVIEWER [Signature]		51. SIGNATURE OF INTERVIEWER [Signature]	
52. SIGNATURE OF INTERVIEWER [Signature]		53. SIGNATURE OF INTERVIEWER [Signature]		54. SIGNATURE OF INTERVIEWER [Signature]	
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58. SIGNATURE OF INTERVIEWER [Signature]		59. SIGNATURE OF INTERVIEWER [Signature]		60. SIGNATURE OF INTERVIEWER [Signature]	
61. SIGNATURE OF INTERVIEWER [Signature]		62. SIGNATURE OF INTERVIEWER [Signature]		63. SIGNATURE OF INTERVIEWER [Signature]	
64. SIGNATURE OF INTERVIEWER [Signature]		65. SIGNATURE OF INTERVIEWER [Signature]		66. SIGNATURE OF INTERVIEWER [Signature]	
67. SIGNATURE OF INTERVIEWER [Signature]		68. SIGNATURE OF INTERVIEWER [Signature]		69. SIGNATURE OF INTERVIEWER [Signature]	
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79. SIGNATURE OF INTERVIEWER [Signature]		80. SIGNATURE OF INTERVIEWER [Signature]		81. SIGNATURE OF INTERVIEWER [Signature]	
82. SIGNATURE OF INTERVIEWER [Signature]		83. SIGNATURE OF INTERVIEWER [Signature]		84. SIGNATURE OF INTERVIEWER [Signature]	
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8386 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>TALBOT</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>TALBOT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 EASTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EASTON MEMORIAL</i>		d. STREET ADDRESS <i>HAMMOND ST. P.O. BOX 377</i>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>L.</i> Last <i>Cephas</i>		4. DATE OF DEATH Month <i>July</i> Day <i>11</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 27 1892</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Moses Cephas</i>		14. MOTHER'S MAIDEN NAME <i>Emma Boston</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>600.0</i> DUE TO <i>Chemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic pyelonephritis</i> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/11/1916</i> to <i>19</i> , that I last saw the deceased alive on <i>5/10/1959</i> , and that death occurred at <i>5:40</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>		ADDRESS (Street, city or town, state) <i>2195 Washington St. Md.</i> DATE SIGNED <i>12/11/59</i>	
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		<i>Easton Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/15/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Richards Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Easton Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Lashied</i> ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 15 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Carlton L. Kline</i>

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed, should be filed with the TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3388 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-PATHOLOGIC 18

See Dist. 10

PLACE IN BOX

DEATH

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX AT DEATH

RACE AT DEATH

EDUCATION AT DEATH

OCCUPATION AT DEATH

RELIGION AT DEATH

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PLACE OF BIRTH AT DEATH

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CAUSE OF DEATH AT DEATH

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SEX AT DEATH AT DEATH

RACE AT DEATH AT DEATH

EDUCATION AT DEATH AT DEATH

OCCUPATION AT DEATH AT DEATH

RELIGION AT DEATH AT DEATH

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PLACE OF BIRTH AT DEATH

DATE OF DEATH AT DEATH

PLACE OF DEATH AT DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>none</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>313 Elm Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Easton Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Taylor</i> Last <i>Claggett</i>		4. DATE OF DEATH Month <i>July</i> Day <i>19</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 1, 1958</i>
9. AGE (In years last birthday) <i>17</i> yrs.		10. IF UNDER 1 YEAR Months <i>17</i> Days <i>18</i> Hours <i>18</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lawrence J. Claggett</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Bowman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no (as enlisted)) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Dr. Lawrence J. Claggett</i>		Address <i>Easton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>"ARALEN" (CHLOROQUINE) POISONING</i> 874.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2-3 HRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>BABY ATE MEDICINE FROM MEDICINE CABINET</i>	
20c. TIME OF INJURY Month, Day, Year <i>7-19-59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>G-P HOME</i>		20f. (City or town) (County) (State) <i>NR EASTON TALBOT MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Louis Multy</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>WELTY</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7-20-59</i>	
22a. BURIAL (CREMATION REMOVAL) (specify) <i>July 22, 1959</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. House</i>		ADDRESS <i>Easton MD</i>	
24a. REC'D BY REGISTRAR <i>JUL 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. House</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON RURAL c. LENGTH OF STAY IN 1b 67x 3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Air Station		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakehurst, N.J. d. STREET ADDRESS U.S. Naval Air Station e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice E Collmer		4. DATE OF DEATH Month JULY Day 27 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1929
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt(jg) USN		10b. KIND OF BUSINESS OR INDUSTRY USN	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME M. E. Collmer		14. MOTHER'S MAIDEN NAME Marguerite C. (dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes active		16. SOCIAL SECURITY NO. 544 26 6946	
17. INFORMANT U.S. Navy records, Lakehurst, N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE SEVERE INJURIES 860x DUE TO (b) HELICOPTER CRASH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH IMMED			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HELICOPTER CRASHED	
20c. TIME OF INJURY Month, Day, Year 7-27 1959 Hour 6:12N a. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) NR EASTON TALBOT MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis S. Welty EXAMINER'S NAME (Type) LOUIS S. WELTY		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/28/59	
22c. NAME OF CEMETERY OR CREMATORY Navel Hosp.		22d. LOCATION (City, town, or county) (State) Phila. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE AUG 11 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Hines			

W. Frampton Carroll

8413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First CARRIE Middle C. Last CROCKETT		4. DATE OF DEATH Month July Day 1 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Thompson		14. MOTHER'S MAIDEN NAME Mary Anna Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sarah Crockett		Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Pneumonia DUE TO (b) Carcinoma of rectum Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 mos 5 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from April 19 59 to July 19 59 , that I last saw the deceased alive on July 12 59 , and that death occurred at 10:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pox 482, St. Michaels, Md DATE SIGNED 7-2-59 ACTUAL SIGNATURE R. Lance Wroth M.D. PHYSICIAN'S NAME (Type) Dr. R. Lance Wroth St. Michaels, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8413

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

THE DAY OF

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>		<p>4. DATE OF BIRTH [Handwritten: 10/15/1900]</p>		<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>	
<p>6. OCCUPATION [Handwritten: Clerk]</p>		<p>7. MARITAL STATUS [Handwritten: Married]</p>		<p>8. DATE OF DEATH [Handwritten: 11/10/1945]</p>		<p>9. PLACE OF DEATH [Handwritten: Home]</p>		<p>10. CAUSE OF DEATH [Handwritten: Heart Disease]</p>	
<p>11. SIGNATURE OF DECEASED [Signature]</p>		<p>12. SIGNATURE OF WITNESS [Signature]</p>		<p>13. SIGNATURE OF DECEASED [Signature]</p>		<p>14. SIGNATURE OF WITNESS [Signature]</p>		<p>15. SIGNATURE OF DECEASED [Signature]</p>	
<p>16. SIGNATURE OF DECEASED [Signature]</p>		<p>17. SIGNATURE OF WITNESS [Signature]</p>		<p>18. SIGNATURE OF DECEASED [Signature]</p>		<p>19. SIGNATURE OF WITNESS [Signature]</p>		<p>20. SIGNATURE OF DECEASED [Signature]</p>	
<p>21. SIGNATURE OF DECEASED [Signature]</p>		<p>22. SIGNATURE OF WITNESS [Signature]</p>		<p>23. SIGNATURE OF DECEASED [Signature]</p>		<p>24. SIGNATURE OF WITNESS [Signature]</p>		<p>25. SIGNATURE OF DECEASED [Signature]</p>	
<p>26. SIGNATURE OF DECEASED [Signature]</p>		<p>27. SIGNATURE OF WITNESS [Signature]</p>		<p>28. SIGNATURE OF DECEASED [Signature]</p>		<p>29. SIGNATURE OF WITNESS [Signature]</p>		<p>30. SIGNATURE OF DECEASED [Signature]</p>	
<p>31. SIGNATURE OF DECEASED [Signature]</p>		<p>32. SIGNATURE OF WITNESS [Signature]</p>		<p>33. SIGNATURE OF DECEASED [Signature]</p>		<p>34. SIGNATURE OF WITNESS [Signature]</p>		<p>35. SIGNATURE OF DECEASED [Signature]</p>	
<p>36. SIGNATURE OF DECEASED [Signature]</p>		<p>37. SIGNATURE OF WITNESS [Signature]</p>		<p>38. SIGNATURE OF DECEASED [Signature]</p>		<p>39. SIGNATURE OF WITNESS [Signature]</p>		<p>40. SIGNATURE OF DECEASED [Signature]</p>	
<p>41. SIGNATURE OF DECEASED [Signature]</p>		<p>42. SIGNATURE OF WITNESS [Signature]</p>		<p>43. SIGNATURE OF DECEASED [Signature]</p>		<p>44. SIGNATURE OF WITNESS [Signature]</p>		<p>45. SIGNATURE OF DECEASED [Signature]</p>	
<p>46. SIGNATURE OF DECEASED [Signature]</p>		<p>47. SIGNATURE OF WITNESS [Signature]</p>		<p>48. SIGNATURE OF DECEASED [Signature]</p>		<p>49. SIGNATURE OF WITNESS [Signature]</p>		<p>50. SIGNATURE OF DECEASED [Signature]</p>	
<p>51. SIGNATURE OF DECEASED [Signature]</p>		<p>52. SIGNATURE OF WITNESS [Signature]</p>		<p>53. SIGNATURE OF DECEASED [Signature]</p>		<p>54. SIGNATURE OF WITNESS [Signature]</p>		<p>55. SIGNATURE OF DECEASED [Signature]</p>	
<p>56. SIGNATURE OF DECEASED [Signature]</p>		<p>57. SIGNATURE OF WITNESS [Signature]</p>		<p>58. SIGNATURE OF DECEASED [Signature]</p>		<p>59. SIGNATURE OF WITNESS [Signature]</p>		<p>60. SIGNATURE OF DECEASED [Signature]</p>	
<p>61. SIGNATURE OF DECEASED [Signature]</p>		<p>62. SIGNATURE OF WITNESS [Signature]</p>		<p>63. SIGNATURE OF DECEASED [Signature]</p>		<p>64. SIGNATURE OF WITNESS [Signature]</p>		<p>65. SIGNATURE OF DECEASED [Signature]</p>	
<p>66. SIGNATURE OF DECEASED [Signature]</p>		<p>67. SIGNATURE OF WITNESS [Signature]</p>		<p>68. SIGNATURE OF DECEASED [Signature]</p>		<p>69. SIGNATURE OF WITNESS [Signature]</p>		<p>70. SIGNATURE OF DECEASED [Signature]</p>	
<p>71. SIGNATURE OF DECEASED [Signature]</p>		<p>72. SIGNATURE OF WITNESS [Signature]</p>		<p>73. SIGNATURE OF DECEASED [Signature]</p>		<p>74. SIGNATURE OF WITNESS [Signature]</p>		<p>75. SIGNATURE OF DECEASED [Signature]</p>	
<p>76. SIGNATURE OF DECEASED [Signature]</p>		<p>77. SIGNATURE OF WITNESS [Signature]</p>		<p>78. SIGNATURE OF DECEASED [Signature]</p>		<p>79. SIGNATURE OF WITNESS [Signature]</p>		<p>80. SIGNATURE OF DECEASED [Signature]</p>	
<p>81. SIGNATURE OF DECEASED [Signature]</p>		<p>82. SIGNATURE OF WITNESS [Signature]</p>		<p>83. SIGNATURE OF DECEASED [Signature]</p>		<p>84. SIGNATURE OF WITNESS [Signature]</p>		<p>85. SIGNATURE OF DECEASED [Signature]</p>	
<p>86. SIGNATURE OF DECEASED [Signature]</p>		<p>87. SIGNATURE OF WITNESS [Signature]</p>		<p>88. SIGNATURE OF DECEASED [Signature]</p>		<p>89. SIGNATURE OF WITNESS [Signature]</p>		<p>90. SIGNATURE OF DECEASED [Signature]</p>	
<p>91. SIGNATURE OF DECEASED [Signature]</p>		<p>92. SIGNATURE OF WITNESS [Signature]</p>		<p>93. SIGNATURE OF DECEASED [Signature]</p>		<p>94. SIGNATURE OF WITNESS [Signature]</p>		<p>95. SIGNATURE OF DECEASED [Signature]</p>	
<p>96. SIGNATURE OF DECEASED [Signature]</p>		<p>97. SIGNATURE OF WITNESS [Signature]</p>		<p>98. SIGNATURE OF DECEASED [Signature]</p>		<p>99. SIGNATURE OF WITNESS [Signature]</p>		<p>100. SIGNATURE OF DECEASED [Signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8388

CERTIFICATE OF DEATH

08369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>G</u> Last <u>FRAZIER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND - USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William FRAZIER</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-26-1827A</u>	
17. INFORMANT <u>Mrs. Walter Collins Brumfield</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a c v d</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>59</u> to <u>7/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>59</u> , and that death occurred at <u>4:40 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON, MARYLAND</u> DATE SIGNED <u>193 Cox</u> M.D.			
ACTUAL SIGNATURE <u>193 Cox</u> M.D.			
PHYSICIAN'S NAME (Type) <u>DOCTOR P. EVANS COX</u> <u>EASTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Windy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Windy Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Veerman & Son</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 3 '59</u>	
ADDRESS <u>Easton, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

CERTIFICATE OF DEATH

3388

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF DECEASED
14. SIGNATURE OF NEXT OF KIN
15. SIGNATURE OF CLERGYMAN
16. SIGNATURE OF MINISTER
17. SIGNATURE OF CHURCH
18. SIGNATURE OF FUNERAL HOME
19. SIGNATURE OF BURIAL PLACE
20. SIGNATURE OF INTERMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8389 CERTIFICATE OF DEATH

Reg. Dist. No.

08370

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	
c. LENGTH OF STAY IN 1b <i>40 yrs</i>		d. STREET ADDRESS <i>208 Suddens St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>J.</i> Last <i>Hammond</i>		4. DATE OF DEATH Month <i>July</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 24, 1886</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Doctor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Medical Dr.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Stewart Hammond</i>		14. MOTHER'S MAIDEN NAME <i>Althea Rebecca Willitt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>218-40-5563</i>	
17. INFORMANT <i>Wm. J. Hammond Jr.</i>		Address <i>Easton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart & vessels</i> DUE TO (c) <i>Sudden</i> 2 yrs			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/9/59</i> , 19 <i>58</i> , to <i>7/10/59</i> , that I last saw the deceased alive on <i>7/9/59</i> , 19 <i>59</i> , and that death occurred at <i>12:4</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P. E. Cox</i>		ADDRESS (Street, city or town, state) <i>Easton</i> DATE SIGNED <i>7/10/59</i>	
PHYSICIAN'S NAME (Type) <i>P. E. Cox</i>			
22a. BURIAL (CREMATION) REMOVAL (Specify) <i>July 13 59</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Hammond Jr.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>William J. Hammond Jr.</i>

CERTIFICATE OF DEATH

1988

05870

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>10/15/88</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. OCCUPATION <i>Teacher</i></p>		<p>8. MARITAL STATUS <i>Married</i></p>		<p>9. PLACE OF BIRTH <i>USA</i></p>	
<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>13. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>14. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>15. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>16. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>17. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>18. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>19. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>20. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>21. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
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<p>25. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>26. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>27. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
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<p>49. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>50. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>51. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>52. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>53. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>54. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
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<p>61. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>62. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>63. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
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<p>67. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>68. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>69. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>70. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>71. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>72. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>73. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>74. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>75. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>76. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>77. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>78. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>79. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>80. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>81. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>82. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>83. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>84. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>85. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>86. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>87. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>88. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>89. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>90. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>91. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>92. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>93. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>94. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>95. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>96. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>97. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>98. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>99. SIGNATURE OF DECEASED <i>[Signature]</i></p>	
<p>100. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>101. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>102. SIGNATURE OF DECEASED <i>[Signature]</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08371

8390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>25 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		1 d. STREET ADDRESS <u>x Royal Oak</u>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>W</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Care Home</u>	9. AGE (In years last birthday) <u>56</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Penn'a</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey C. Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Julia Shively</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unit) <u>No</u>		16. SOCIAL SECURITY NO. <u>Stone</u>	
17. INFORMANT <u>Self</u>		Address <u>Living on admission</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic peritonitis</u> DUE TO <u>Thrombosis Superior mesenteric artery</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>artery</u> DUE TO <u>artery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>p. m.</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1959</u> , to <u>1959</u> , that I last saw the deceased alive on <u>July 19, 1959</u> and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>2195. 21st July 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Funchliff</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Christie</u>		24a. REC'D BY REGISTRAR <u>Easton</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

CERTIFICATE OF DEATH

Reg. Dist. No.

09542

8391

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN TB <u>13 hrs. 20 mins</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES DAVIDSON IRELAND</u>				4. DATE OF DEATH Month Day Year <u>7 9 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1917 NOV. 5, 1917</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BIGGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES IRELAND</u>				14. MOTHER'S MAIDEN NAME <u>NEILLIE FLUHARTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WWIL</u>		17. INFORMANT Address <u>MRS. Lillian IRELAND EASTON, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:15</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				DATE SIGNED <u>2195 Washington St. 9 July 59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton Md, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Conell</u>				ADDRESS <u>EASTON, MD</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8392 CERTIFICATE OF DEATH

08372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>16 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Centreville</u>	
3. NAME OF DECEASED (Type or print) <u>William T. James</u>		4. DATE OF DEATH <u>7</u> Month <u>16</u> Day <u>1959</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rained</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labrador</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William James</u>		14. MOTHER'S MAIDEN NAME <u>Clintonia Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>141-01-3112</u>	
17. INFORMANT <u>Blanche E. James</u>		Address <u>Centerville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15, 1959</u> , to <u>7-16, 1959</u> , that I last saw the deceased alive on <u>7-16, 1959</u> , and that death occurred at <u>2:27</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		ADDRESS (Street, city or town, state) <u>202 Dover St. Easton Md.</u>	
DATE SIGNED <u>7-17-59</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		ADDRESS <u>Easton Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY— <u>Bransville</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Burt</u>		ADDRESS <u>Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18373

8393 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>16 days - 2 hrs - 40</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>Herman + Jarboe Canal</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Anthony</u> First <u>Jones</u> Middle <u>Jones</u> Last		4. DATE OF DEATH <u>July 7</u> 19 <u>59</u> Month <u>July</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>10</u> yrs. <u>2</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Mins
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Jennie Mae Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Jennie Mae Jones, same - mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>776x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 25</u> , 19 <u>59</u> , to <u>July 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 4</u> , and that death occurred at <u>2:50</u> P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>219 S. West St. Hagerstown, Md.</u>		<u>July 7, 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. D. Smith</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JUL 21 '59</u>	
24b. REGISTRAR'S SIGNATURE			

2080243XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08374

8394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>USA Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cordova</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles C Kinnaman</u>				4. DATE OF DEATH Month Day Year <u>July 27 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 7, 1896</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Kinnaman</u>				14. MOTHER'S MAIDEN NAME <u>Emma Chambers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Harry Kinnaman, Cordova Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1</u> , 19 <u>59</u> , to <u>19</u> , that I last saw the deceased alive on <u>7/27/59</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>P. Evans Cox</u> <u>Easton, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 30, 59 Spring Hill</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Easton</u>		22d. LOCATION (City, town, county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		DATE OF DEATH [Faint handwritten date]	
PLACE OF DEATH [Faint handwritten address]		COUNTY [Faint handwritten county name]	
SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause of death]	
MANNER OF DEATH [Faint handwritten manner of death]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF REGISTRAR [Faint handwritten signature]		DATE OF REGISTRATION [Faint handwritten date]	

ADULT IN 18

8395 CERTIFICATE OF DEATH

08375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Shedd</u> Last <u>Lally</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deceased</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lally</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Shedd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>10-10-10-10-10</u>	
17. INFORMANT <u>Mr. Elizabeth Hale Lally</u>		Address <u>334 Concliff Ave Dayton, Ohio</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadillac arrest</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Marked coronary thrombosis</u> (c) <u>Electrolyte imbalance</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>duodenal ulcers</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>2195 Washington St 20 July 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton 6, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 27, 59</u>		22b. DATE THEREOF <u>July 27, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Black</u>		24a. REC'D BY REGISTRAR <u>Easton Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		DATE JUL 24 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 23 Film G244 7/13/59 cap

118376

8396 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		STATE <u>Maryland</u> COUNTY <u>Talbot</u>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
TOWN <u>Easton</u>		LENGTH OF STAY (in this place) <u>5 years</u>		STREET ADDRESS <u>401 S. Washington</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 S. Washington</u>				STREET ADDRESS <u>401 S. Washington</u>			
3. NAME OF DECEASED (Type or Print) <u>TELFORD</u> (First) <u>LEWIS</u> (Last)				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>3</u> (Year) <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 20, 1873</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mining engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coal</u>		11. BIRTHPLACE (State or foreign country) <u>Bairsville, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>175-16-8439</u>		17. INFORMANT & ADDRESS <u>Chas. S. Lewis, Easton, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1450.0 IMMEDIATE CAUSE (A) <u>Arteriosclerosis, generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs. 1</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>UNDERLYING CAUSE LAST.</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> at work Not white <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u> , to <u>7-3-</u> , <u>1959</u> , that I last saw the deceased alive on <u>7/2/59</u> , <u>1959</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. C. Cot</u>		M.D. <u>Easton Md</u>		ADDRESS (Street, city, town, state) <u>714/59</u>		DATE SIGNED (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial + Burial</u>		DATE THEREOF <u>July 5, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>		LOCATION (City, town, or county) <u>Johnstown, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>JUL 10 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Ellis Clark per reg.</u>		ADDRESS <u>Easton, Md.</u>	
DATE							

8397 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 29 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORDOVA	
4. DATE OF DEATH First CHARMAINE Middle JUNE Last MARTH		4. DATE OF DEATH Month JULY Day 21 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 22, 1959
9. AGE (In years last birthday) 29 DAYS		IF UNDER 1 YEAR: Months 29 Days 29 Hours 29 Min. 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CONROY MARTIN JR.		14. MOTHER'S MAIDEN NAME DORIS JOSEPHINE SUMP.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT "MOTHER"		Address CORDOVA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 751X DUE TO Psychrophthalmus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sub-acute meningitis DUE TO Sub-acute meningitis (c) Sub-acute meningitis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 to 1959 , that I last saw the deceased alive on July 21, 1959 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt M.D.		DATE SIGNED 21 July 59	
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		ADDRESS (Street, city or town, state) 215 Washington St. Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) July 22, 59		22b. DATE THEREOF July 22, 59	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill		22d. LOCATION (City, town, or county) (State) Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE A. Ellis Clark		24a. REC'D BY REGISTRAR Jul 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

2080262XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 6244 7-14-59 et

08378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	c. LENGTH OF STAY IN 1b 10 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		d. STREET ADDRESS 119 S. HARRISON ST	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last TILGHMAN McCABE		4. DATE OF DEATH 12:01A Month Day Year JULY 6 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 22, 1908
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GIFT SHOP		10b. KIND OF BUSINESS OR INDUSTRY OWN SHOP	11. BIRTHPLACE (State or foreign country) SALISBURY MD
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM H. McCABE	
14. MOTHER'S MAIDEN NAME HARRIET TILGHMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM H. McCABE Address OCEAN CITY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BARBITURATE POISONING 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC HEART DISEASE C MITRAL STENOSIS & INSUFFICIENCY			INTERVAL BETWEEN ONSET AND DEATH HOURS
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) TOOK OVERDOSE OF TUINAL	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7-5 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) (County) (State) EASTON TALBOT MD
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Louis S. Welty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) LOUIS S. WELTY ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY PARSONS CEM	22d. LOCATION (City, town, or county) (State) SALISBURY MD
23. FUNERAL DIRECTOR'S SIGNATURE Peter Phaley		24a. REC'D BY REGISTRAR DATE JUL 10 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

MDIAN: The law requires that the death certificate be executed
attending physician.
certificate has been signed by the attending physician and compl
as the burial-transit permit. Then please remove.

in 24 hours after death: Page 4

the funeral director,
y filled in
pages 1

should be filled with

8399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u> <u>09x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>McWilliams</u> Last <u>McWilliams</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 13, 1899</u>	9. AGE (If years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Sally Thompson Brinfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sally Thompson Brinfield</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>3 hrs.</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>7-11</u> , 19 <u>59</u> , to <u>7-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>59</u> , and that death occurred at <u>8:53 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>Robert W. Trever</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D.		PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith S. Kelloggby East New Market, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

carbon papers, use, emission, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08380

Items 8, 9 Film 6244 7-21-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL Hosp.</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First Middle Last				4. DATE OF DEATH <u>MURRAY</u> Month <u>7</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>-Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1911</u>	9. AGE (in years last birthday) <u>48</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Dyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WWH 144-16-0821</u>		17. INFORMANT <u>Josephine Brown</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis Merty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-6-59</u>			
EXAMINER'S NAME (Type) <u>INELTV</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harmony Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Bloch, Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>218 S. Washington St.</u>		d. STREET ADDRESS <u>218 S. Washington St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nelle</u> Middle <u>Loft</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>0</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Heaton West. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John R. Gatt</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. W. J. Palmer, Easton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>181.0</u> DUE TO <u>3 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Car on one tire</u> DUE TO <u>14 months</u> (c) <u>A down car on</u> <u>14 months</u> <u>7 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Heart trouble</u> <u>Family</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19, 1952</u> to <u>July 26, 1959</u> that I last saw the deceased alive on <u>July 26, 1959</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>July 27, 1959</u>			
ACTUAL SIGNATURE <u>M. V. Palmer</u> M.D.			
PHYSICIAN'S NAME (Type) <u>M. V. Palmer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 29, 1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rollis Camp</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>UL 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		1. d. STREET ADDRESS <u>x BOZMAN</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Richardson</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary heart d.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia, chronic metabolic abnormalities</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>aug 52</u> , 19 <u>52</u> to <u>30 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>30 July</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm M. Reeker</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels md</u> DATE SIGNED <u>7-31-59</u>	
PHYSICIAN'S NAME (Type) <u>Wm M. Reeker</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-1-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bozman Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bozman md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Hamilton Harrison</u> ADDRESS <u>St. Michaels md</u>		24. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2402

Page One of

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 5, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
19. SIGNATURE OF CORONER JAMES EARL RAY		20. SIGNATURE OF JURY JAMES EARL RAY		21. SIGNATURE OF JUDGE JAMES EARL RAY	
22. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		23. SIGNATURE OF CLERK JAMES EARL RAY		24. SIGNATURE OF REGISTRAR JAMES EARL RAY	
25. SIGNATURE OF HEALTH COMMISSIONER JAMES EARL RAY		26. SIGNATURE OF STATE DEPARTMENT OF HEALTH JAMES EARL RAY		27. SIGNATURE OF BALTIMORE CITY DEPARTMENT OF HEALTH JAMES EARL RAY	
28. SIGNATURE OF MARYLAND DEPARTMENT OF HEALTH JAMES EARL RAY		29. SIGNATURE OF UNITED STATES DEPARTMENT OF HEALTH JAMES EARL RAY		30. SIGNATURE OF NATIONAL BUREAU OF HEALTH JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08383

8403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>38</u> 40 <u>EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1527 S. Washington St</u>	
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>C</u> Last <u>Riddell</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27 1882</u> 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police and Employee Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
13. FATHER'S NAME <u>Robert Riddell</u>		14. MOTHER'S MAIDEN NAME <u>Hannie Daggig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-46-22387</u>	
17. INFORMANT <u>Mrs Guy L. Riddell</u> Address <u>Baton Rd</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>40.5</u> <u>YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>49</u> , to <u>7/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/18</u> , 19 <u>59</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Shepard Kroch Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>EASTON</u> DATE SIGNED <u>7/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Shepard Kroch Jr</u> Md.			
22a. BURIAL (CREMATION, REMOVAL) (Specify)	22b. DATE THEREOF <u>July 20, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Riddell</u> ADDRESS <u>Baton, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

CERTIFICATE OF DEATH

8403

Age 64 M

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		White		1/1/1910		1/15/1975		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Usual residence		12. Usual occupation		13. Usual place of birth		14. Usual place of death		15. Usual place of burial		16. Usual place of residence at death		17. Usual place of death		18. Usual place of death		19. Usual place of death		20. Usual place of death	
1900 N. Main St.		Teacher		Maryland		Home		Home		Home		Home		Home		Home		Home	
21. Usual place of death		22. Usual place of death		23. Usual place of death		24. Usual place of death		25. Usual place of death		26. Usual place of death		27. Usual place of death		28. Usual place of death		29. Usual place of death		30. Usual place of death	
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1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Manner of death
9. Signature of physician
10. Signature of registrar
11. Usual residence
12. Usual occupation
13. Usual place of birth
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100. Usual place of death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08384

8404 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Chester 17x-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>G.</u> Last <u>Sehnke</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Leimbach</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Wenzel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>319-28-7318</u>		17. INFORMANT <u>Mrs. Ethel Maher - Chester, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basilar artery thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarction. Parkinsonism</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10:40 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 DOVER ST. EASTON, M.D.</u> DATE SIGNED <u>7-19-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u>		PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER EASTON, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Sanders + Son</u> ADDRESS <u>N. Ave. Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>Jul 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

Page One of Two

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF OTHER	

BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8414

CERTIFICATE OF DEATH

08385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		c. LENGTH OF STAY IN 1b 55yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle V.. SINCLAIR Last		4. DATE OF DEATH Month July Day 10, Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? V. S.	
13. FATHER'S NAME Joseph Fairbank		14. MOTHER'S MAIDEN NAME Josephine Pumphrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 216-09-4438D	
17. INFORMANT Mr. Price Sinclair		Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH acute			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 58 , to 7/10 , 19 59 , that I last saw the deceased alive on 7/10 , 19 59 , and that death occurred at 3:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. L. J. Eglseder M.D. 12 N. HANSON ST. EASTON, MD. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 13, 1959 22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery 22d. LOCATION (City, town, or county) (State) Oxford, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
24b. REGISTRAR'S SIGNATURE Critter L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

8405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>5 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Memorial Hosp.</u>				e. STREET ADDRESS <u>221 Denton Road.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Stanley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1 1959</u>	
9. AGE (In years last birthday) <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>5</u> Min <u>5</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Maurice Purwell Stanley</u>				14. MOTHER'S MAIDEN NAME <u>Martha Virginia Ricketts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martha Stanley, mother - same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Failure</u> DUE TO <u>Immaturity (6 months old)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity (6 months old)</u> DUE TO (c) <u>Immaturity (6 months old)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7-1</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7-1</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7:30 A.M.</u> , 19 <u>59</u> , to <u>7:30 P.M.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-3-59</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Federalsburg, Md.</u> DATE SIGNED <u>7-3-59</u>							
ACTUAL SIGNATURE <u>H. R. Trapnell</u> M.D.				DATE SIGNED <u>7-3-59</u>			
PHYSICIAN'S NAME (Type) <u>H. R. Trapnell</u>				M.D. <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Trapnell</u> ADDRESS <u>Federalsburg, Md.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JUL 10 '59</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after filling in the certificate, has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08387

8406 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i> 05x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <i>TALMAGE A.R. STRONG</i>				4. DATE OF DEATH Month Day Year <i>7 22 1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 31, 1899</i>		9. AGE (In years last birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Life insurance</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Christopher Strong</i>				14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Adams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>1</i>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Essential hypertension</i>							INTERVAL BETWEEN ONSET AND DEATH <i>< 1 hr.</i> <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Essential hypertension</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>mid</i> 1958, to <i>1 week ago</i> , 1959, that I last saw the deceased alive on <i>1 week ago</i> , 1959, and that death occurred at <i>M</i> , from the causes and on the date stated above. <i>DOA on arrival at Memorial Hospital, Easton</i> ADDRESS (Street, city or town, state) DATE SIGNED <i>Robert W. Trever</i> M.D. <i>202 Dover St.</i> <i>7-22-59</i>							
ACTUAL SIGNATURE <i>Robert W. Trever</i> M.D. <i>202 Dover St.</i> <i>7-22-59</i>							
PHYSICIAN'S NAME (Type) <i>Robert W. TREVER</i> <i>Easton, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>July 26, 1959</i>		<i>Denton</i>		<i>Denton, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>George Deanebow Denton</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8407 Item 3 Film 0246 8-10-59 et CERTIFICATE OF DEATH

08388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Brookletts Avenue			
d. STREET ADDRESS 211 Brookletts Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George GARRETT PERCY TARBUTTON				4. DATE OF DEATH Month Day Year July 26, 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Tarbutton				14. MOTHER'S MAIDEN NAME Emily J. Tarbutton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-7445		17. INFORMANT Mrs. Ethal Tarbutton		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Coronary Insufficiency Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 minute 9 yr 12 yr -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 42 to July 26 19 59 that I last saw the deceased alive on July 26 , 19 59 , and that death occurred at 7:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington St. Easton, Maryland DATE SIGNED July 28, 1959							
ACTUAL SIGNATURE for Dr. W. N. Palmer M.D.							
PHYSICIAN'S NAME (Type) Dr. W. N. Palmer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

6407

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>		<p>3. AGE 64</p>	
<p>4. RACE White</p>		<p>5. BIRTH DATE 1881</p>		<p>6. BIRTH PLACE Baltimore, Md.</p>	
<p>7. DECEASED'S RESIDENCE 1234 N. E. St., Baltimore, Md.</p>		<p>8. DECEASED'S OCCUPATION Clerk</p>		<p>9. DECEASED'S MARITAL STATUS Married</p>	
<p>10. DECEASED'S DATE OF DEATH July 1, 1942</p>		<p>11. DECEASED'S TIME OF DEATH 10:30 A.M.</p>		<p>12. DECEASED'S PLACE OF DEATH Home</p>	
<p>13. DECEASED'S CAUSE OF DEATH Heart Disease</p>		<p>14. DECEASED'S MANNER OF DEATH Natural</p>		<p>15. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>16. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>17. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>18. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>19. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>20. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>21. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>22. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>23. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>24. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>25. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>26. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>27. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>28. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>29. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>30. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>31. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>32. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>33. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>34. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>35. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>36. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>37. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>38. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>39. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>40. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>41. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>42. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>43. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>44. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>45. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>46. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>47. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>48. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>49. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>50. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>51. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>52. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>53. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>54. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>55. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>56. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>57. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>58. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>59. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>60. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>61. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>62. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>63. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>64. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>65. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>66. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>67. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>68. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>69. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>70. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>71. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>72. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>73. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>74. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>75. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>76. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>77. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>78. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>79. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>80. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>81. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>82. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>83. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>84. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>85. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>86. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>87. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>88. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>89. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>90. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>91. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>92. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>93. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>94. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>95. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>96. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>97. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>98. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>99. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	
<p>100. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>101. DECEASED'S SIGNATURE JAMES H. HARRIS</p>		<p>102. DECEASED'S SIGNATURE JAMES H. HARRIS</p>	

8415

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18389

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY TALBOT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON - Rural		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST MICHAELS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —			d. STREET ADDRESS Chestnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Thomas Last Wharton			4. DATE OF DEATH Month July Day 4 Year 1959		
5. SEX MALE	6. COLOR OR RACE IN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15 1895	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 6 Days 4 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY COMMERCIAL		11. BIRTHPLACE (State or foreign country) St. Michaels, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WILLIAM T. WHARTON JR.		
14. MOTHER'S MAIDEN NAME MOLLIE SEYMOUR			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. —			17. INFORMANT Mrs Ruth Wharton, St. Michaels, Md.		
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH md.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 6 7 4 59		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wye River	
20f. (City or town) Talbot		20g. (County) md		20h. (State) md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Louis M. W. KTY			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) W E KTY			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 6, 1959		22b. DATE THEREOF July 6, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	
22d. LOCATION (City, town, or county) St. Michaels Md.		22e. (State) md		22f. (County) md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Hamilton Harrison, St. Michaels, Md.			24a. REC'D BY REGISTRAR JUL 8 '59		
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw...			24c. DATE JUL 8 '59		

8408 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bozman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>B</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 18, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennery Williams</u>		14. MOTHER'S MAIDEN NAME <u>Annie Holtz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Vergie St. Duncan, Bozman, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic coronary heart d.</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebrovascular occlusion, cachexia generalized.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-59</u> , to <u>2-22-59</u> , that I last saw the deceased alive on <u>2-22-59</u> , and that death occurred at <u>7:20 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>My Michael</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Michaels Md</u>	
PHYSICIAN'S NAME (Type) <u>My Michael</u>		DATE SIGNED <u>7-28-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Hampton Harrison</u>		ADDRESS <u>St. Michaels</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate filled in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete the certificate filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10,14,15,16,17 Film G244 7-15-59 et

8409

CERTIFICATE OF DEATH

Reg. Dist. No.

08391

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>108 S. HARRISON ST</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>William</u> Middle <u>William</u> Last <u>Williams</u>		4. DATE OF DEATH <u>7</u> Month <u>10</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Dir. and Antique dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward T. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Mianer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-7721</u>	
17. INFORMANT <u>J. H. Williamson, Federalsburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>219X Post operative vascular collapse 5 hours</u> DUE TO (b) <u>Removal of foreign bodies from 6 months</u> DUE TO (c) <u>Cerebral infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral infarction</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1941</u> , to <u>July 7, 1959</u> , that I last saw the deceased alive on <u>July 7, 1959</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Talbot Co., Maryland</u> DATE SIGNED <u>7/13/59</u>			
ACTUAL SIGNATURE <u>M. V. Palmer</u> M.D.		PHYSICIAN'S NAME (Type) <u>M. V. Palmer</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 13, 1959</u>		22b. DATE THEREOF <u>July 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Williams - Federalsburg</u> ADDRESS <u>Federalsburg, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kneas</u> DATE <u>JUL 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8410 CERTIFICATE OF DEATH

08392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>140 Harrison & Jarboe</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nathaniel</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2 1902</u>
9. AGE (In years, last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Watts Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Balco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>self</u>		16. SOCIAL SECURITY NO. <u>self</u>	
17. INFORMANT <u>self</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerosis Generalized</u> DUE TO <u>Generalized Debility</u> (c) <u>Generalized Debility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/19</u> 19 <u>59</u> , to <u>30 1/2</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/2</u> 19 <u>59</u> , and that death occurred at <u>10 3/4</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON, MARYLAND</u> DATE SIGNED <u>EASTON, MARYLAND</u>			
ACTUAL SIGNATURE <u>L. J. Eglseder</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. J. EGLESEDER</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Haskett</u> ADDRESS <u>Easton</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1950</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	